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Beyond policy: perspectives of school health practitioners about providing contraception services to school-going adolescents in South Africa

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Abstract

Background Providing contraception to adolescents is a critical intervention in reducing adolescent and early pregnancy. However, many adolescents, including those attending school, still lack access to contraception. We adapted Baroudi's ecological framework of access to healthcare to explore the perspectives of school health practitioners about providing contraceptive services to school-going adolescents.

Methods This is an exploratory qualitative research study. We employed purposive sampling to recruit school health practitioners directly involved in implementing sexual and reproductive health policies or interventions in public secondary schools. From September to October 2023, we conducted semi-structured interviews with forty-nine participants. We followed Braun and Clarke's approach of thematic analysis and adhered to the Consolidated Criteria for Reporting Qualitative Studies checklist for qualitative research reporting.

Results In our study, participants highlighted the importance of having access to accurate information about contraception and being knowledgeable about school health policies. They also identified socio-cultural norms, denialism and misconceptions as potential barriers to contraception access. Notably, they suggested that strengthened parental involvement and the presence of nurses in schools could significantly improve the provision of contraceptive services to school-going adolescents.

Conclusions Our study offers valuable insights into the perspectives of school health practitioners about providing contraception to adolescents. These findings highlight the implications of implementing the Integrated School Health Policy and the Policy on the prevention and management of learner pregnancy in schools. The results of this study could provide valuable insights to policymakers, decision-makers, nurses, and teachers from the Departments of Education and Health. Those insights could enhance the development of school health policies and the implementation of contraception-related programmes for adolescents in secondary schools. This, in turn, would contribute to reducing adolescent pregnancies in South Africa.

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Keywords Contraception, School health practitioners, School-going adolescents, Perspectives, Policy, Provision of contraceptive services, South Africa

Introduction

Adolescents spend most of their daily lives in school, making the education sector an integral part of their development [1]. Schools play an essential role in adolescent sexual and reproductive health (ASRH) and in preventing early and unintended pregnancies [2, 3]. However, in low-and middle-income countries (LMIC), approximately 21 million girls aged between 15 and 19 years and 2 million girls aged below 15 years become pregnant each year [4]. Over 16 million girls aged between 15 and 19, including one million below 15, give birth annually in LMIC [4]. The negative implications of adolescent pregnancy on the education of adolescents include irregular school attendance and dropping out of school [5]. Adolescent and early pregnancy could have other negative consequences for girls [6]. Pregnancy and childrearing at an early age are associated with health risks for adolescents [6, 7]. Adolescents experience pregnancy complications, which could lead to maternal mortality and morbidity [8, 9]. Other implications are increased exposure to sexually transmitted infections (STIs) and financial difficulties [10].

One of the interventions to reduce the negative outcomes of adolescent and early pregnancy is strengthening access to contraception information and services [11]. Providing contraception to school-going adolescents has benefits such as improved use of contraceptive methods and reduction in unintended pregnancies [12]. Other benefits of contraception access include planning and spacing of children, improved knowledge and awareness of contraceptive methods, and reduction of the risk of endometrial and ovarian-related diseases and conditions [3, 13].

According to Baroudi (2023), access is enhanced by accounting for the following interconnected steps: approachability, acceptability, adequacy, affordability, and quality [14]. Approachability refers to the degree to which adolescents are aware of healthcare services and have access to them [14]. Acceptability refers to the extent to which healthcare services meet the social and cultural norms of adolescents [14]. Adequacy refers to how the needs of adolescents in terms of time, location and services are met. Affordability refers to the service fees [14]. Quality refers to the structure and process of providing care [14].

In South Africa, health is a constitutional right, and the country has developed policies that align with the country's Constitution to promote ASRH [15]. These policies emphasise that it is crucial to address the contraception needs of adolescents. The Departments of Basic Education and Health in South Africa, together with school health practitioners such as teachers and care and support assistants (CSAs), nurses, and other stakeholders, have collaborated to implement policies to mitigate the impact of adolescent pregnancy. These policies aim to enhance ASRH by encouraging both the Department of Basic Education (school health practitioners) and the Department of Health (nurses) to provide comprehensive sexuality education (CSE) and contraception to adolescents [16, 17]. In addition, the policies demonstrate a commitment towards improving ASRH.

According to the *Integrated School Health Policy*, school health nurses can provide school-going adolescents older than 14 years with information on contraceptive methods, deliver contraceptive counselling, distribute condoms and refer students to the nearest clinic for additional contraceptive services, following consent from a parent or guardian [18]. Further, teachers can provide curriculum-based CSE, promote life skills development and create supportive environments with the assistance of CSAs [18, 19]. The CSAs provide psychosocial care and support to learners in need and facilitate and coordinate programmes for them. They are also known as learner support agents [20]. The CSAs receive supervisory support from Care and Support Officers (CSOs) who work in the education department's district offices [20].

The *Policy on the Prevention and Management of Learner Pregnancy in Schools* supports the rights of pregnant adolescents to continue their schooling without any discrimination with the help of their families, schools, and communities [21]. The policy makes provisions for school managers, governing bodies (parents), and female adolescents to manage adolescent pregnancy through special measures that will enable adolescents' rights to education [21]. At schools, all support is coordinated through the SBST led by the school principal or his/her designate [20]. However, despite these policies, awareness and uptake of contraception are suboptimal among adolescents, especially boys [16, 22, 23].

Previous research in South Africa shows that adolescents encounter various barriers that hinder their access to contraception [24, 25]. The factors that impede access to contraception include inconvenient clinic hours, quality of services, unsupportive social norms (including cultural or religious opposition), adolescent misconceptions about the use and effects of contraceptive methods, and lack of information on contraceptive methods and sources of methods [26–28]. Access to contraception is particularly challenging in rural and remote locations due

to socioeconomic disadvantages [29]. These include geographic distance to and from healthcare facilities, which could affect travel time and cost [30, 31].

Although contraception is mainly provided at primary healthcare (PHC) facilities or clinics in South Africa, various studies highlight constraints in PHC facilities such as limited operating hours and long wait times [28, 32, 33]. Other research on contraception found that there was limited access to contraception services for young women in urban areas s [29, 31, 34] thus excluding adolescents (male and female) living in rural areas. A study by Nkani and Bhana, along with others, highlighted that it is essential for both the Departments of Health and Basic Education to ensure that young people can easily access comprehensive contraceptive services [31]. Another study conducted among school health nurses emphasised the need for broader research involving perspectives from various school health practitioners [34]. The perspectives of school health practitioners directly or indirectly involved in implementing school health policies and providing ASRH programmes to adolescents in secondary schools in urban and rural areas have yet to receive adequate attention in the literature [5, 31, 35].

The objective of this study, is to explore the perspectives of school health practitioners about the provision of contraception to adolescents using Baroudi's ecological framework. The findings from this study could be used by policymakers and decision-makers from the Departments of Education and Health to improve the implementation of SRH policies and contraception-related interventions for adolescents and to provide support to provincial departments. The Western Cape Education Department (WCED) could also utilise the findings of this study to enhance its systems for the benefit of learners and school health practitioners.

Methods

Study design

We conducted this study as part of a doctoral study using an exploratory qualitative research design. Exploratory qualitative research is conducted to discover new ideas and deepen knowledge about the provision of contraception to adolescents [35]. This design is well suited for gaining a deep understanding of school health practitioners' lived experiences [36, 37].

Table 1 Description of the study setting

District	City of Cape Town	West Coast
Population Size	4 748 976	476 020
Location	Urban	Rural
Number of Schools	781	121
Proportion of No-Fee Schools	47.8%	71.9%
Primary Healthcare Clinics (excluding mobile and satellite)	126	27
Adolescent Pregnancy Rate	9.8%	15.3%

Source [38, 39]

Study setting

We conducted this study in two districts of the Western Cape province in South Africa: the City of Cape Town Metropolitan Municipality and the West Coast district. The City of Cape Town Metropolitan Municipality is the largest district in the Western Cape, and the West Coast is one of the smaller districts. The City of Cape Town Metropolitan Municipality is an urban area and comprises about 66% of the population, and the West Coast district is a rural area and comprises about 7% of the total population [38, 39]. Table 1 provides an overview of the study setting.

Participants and sampling approach

In this study, we applied a purposive sampling technique [36]. We recruited participants who met the following selection criteria: (a) school health practitioners who were teachers or members of the school management team (SMT) or school-based support team (SBST), as well as care and support assistants (CSAs), (b) employed by the WCED, (c) working in public secondary schools or a district office, and (d) involved in the provision of ASRH support to learners (or school-going adolescents).

Recruitment of study participants

We contacted the district-based personnel and school principals to inform them about the study. The school principals facilitated the recruitment of the SBST members for the study by identifying and informing the relevant teachers. District-based personnel and school principals also assisted in informing the school principals and CSAs about the study, respectively. We invited potential study participants to take part in the study. The participants made their own decisions about participating in the study. We provided detailed information to the possible study participants on the reasons for conducting the study and what would be expected of them if they decided to participate.

This study involved 49 school health practitioners, 35 females and 14 males. Participants comprised secondary school teachers ($N=12$), school principals or deputy principals ($N=7$), district-based CSOs ($N=4$), and CSAs ($N=26$). Table 2 shows the demographic characteristics of the participants.

Data collection

Data collection occurred between August and October 2023 at the participants' preferred location and time to minimise inconvenience and avoid disrupting teaching time. Before commencing, we outlined the study's

Table 2 Demographic characteristics of the study participants

Participant Characteristics	Frequency (*N*)	Percent (%)
Gender		
Female	35	71
Male	14	29
Age		
20–29	12	24
30–39	16	33
40–49	8	16
50–59	10	20
60+	3	6
Racial group		
Black African	16	33
Coloured	31	63
Indian	2	4
Job title		
Care and Support Assistant (CSA)	26	53
Care and Support Officer (CSO)	4	8
Teacher	12	25
School Principal or Deputy Principal	7	14
Location		
City of Cape Town Metropolitan Municipality (urban)	39	80
West Coast District (rural)	10	20
Total	**49**	**100**

objectives and interview procedure, ensuring informed consent. It is worth noting that one of the forty-nine participants refused to give consent for the interview to be audio recorded. TK took detailed notes of the interview, which was not audio-recorded and confirmed the notes with the participant.

We used an interview guide that was informed by relevant literature and incorporated constructs of the ecological framework on access [14]. The interview guide comprised open-ended interview questions that focused on demographic information, views about the approachability and accessibility of school health policies and contraception interventions, adequacy related to the provision of contraception, and quality of SRH interventions implemented at schools, early or adolescent pregnancy, and views about the provision of contraception to adolescents.

We conducted forty-five in-person and four virtual semi-structured interviews through Microsoft Teams. Semi-structured interviews give the researchers and participants flexibility to direct the interviews [37]. We conducted individual interviews to avoid status and power differences influencing responses among participants. While the interviews were primarily conducted in English, a few participants code-switched to isiXhosa or Afrikaans for specific phrases. The interviews, which took 30–60 min, were documented in a reflexive journal to enhance the study's neutral interpretations.

Data analysis

We conducted data analysis by following the process of thematic analysis suggested by Braun and Clarke [40, 41]. The process entails the following steps: (a) familiarisation with the data, (b) generating the initial codes, (c) searching for themes, (d) reviewing the themes, and (e) naming and defining the themes [40, 41]. Therefore, we started by listening to the interview recordings several times, and then TK and a research assistant transcribed forty-eight of the interviews verbatim, translated and back-translated the code-switched phrases. After that, we read the transcriptions while listening to the audio recording to ensure accuracy. Next, TK read the transcriptions and research notes word-for-word to analyse the data and understand the themes. Next, she extracted the themes from the data and conducted the initial analysis. The data was categorised into themes based on the constructs of the ecological framework on access by Baroudi [14]. The themes which were derived from the constructs of the ecological framework on access by Baroudi are (a) approachability, (b) acceptability, (c) adequacy, (d) affordability, and (e) quality [14]. We explored the subthemes developed from the data analysis within each theme. We identified similarities within and across all the transcripts and field notes and reached an agreement after extensive discussions on the themes.

Ensuring rigour

In order to ensure rigour in our study, we followed the four steps outlined by Tolley et al. [36]. We followed these four steps: (a) For *transferability*, we maintained field notes and engaged in reflexive journaling by reflecting on observations and providing a detailed description of the research, the participants' characteristics, and the methods of data collection and analysis. Additionally, we developed complete transcriptions and included documented examples of the participants' quotes. (b) We ensured *dependability* by maintaining an audit trail of the research process, including detailed documentation of the methods used to code the concepts and themes from textual and audio data. (c) We upheld *confirmability* by verifying participants' interview responses and holding regular supervisory meetings to minimise researcher bias. (d) We established *credibility* through extensive data engagement and peer debriefing. Peer debriefing involved analysing the data as soon as it was collected, observing the data analysis process, and validating the codes and categories. We also tried to select the participants solely based on the objectives of the study and free of bias.

Findings

Forty-nine participants (school health practitioners) shared their perspectives about the provision of contraception to adolescents. The study findings, with themes, subthemes and illustrative quotes, are presented in Table 3.

Theme 1: approachability

According to Baroudi's conceptual framework, approachability is the degree to which healthcare services are known and can be used. In this study, approachability refers to practitioners' knowledge about policies related to the provision of contraception interventions and adolescents' awareness of contraception. We identified three subthemes related to this theme: awareness of policies, views about the service offering, and disparities in knowledge.

Awareness of policies

Participants reported that knowledge of policies was essential for seeking, obtaining, utilising, or implementing contraception interventions. Further, participants emphasised that it was essential for them (school health practitioners) to know and be equipped to implement policies, such as the *Policy on the Prevention and Management of Learner Pregnancy in Schools*, despite personal views and beliefs. This policy, in particular, safeguards pregnant girls against discrimination, shaming, or dropping out of school due to pregnancy.

> *Well, obviously, the policy (it is good) for the sake of the pregnant learner [student]…especially girls. They are not marginalised or disadvantaged by not being in school, etc. I mean, for people to put their personal opinions or religious views aside and deal with things the way they're supposed to, you know… That's the policies, they are the rules.*
> *Interview 054, School Principal, Female.*

Table 3 Themes and subthemes

Theme	Subtheme
Approachability	Awareness of policies
	Views about the service offering
	Disparities in knowledge
Acceptability	Different strokes for different folks
	Inadequate support for practitioners
	Support for pregnant and parenting adolescents
Adequacy	Time and location
	Mixed views about making contraceptive methods available
Affordability	When unexpected costs arise
Quality	Quality as defined by service users

The participants emphasised the importance of having parental support for educational contraception interventions or CSE (for adolescents at home and school health practitioners at school) as well as communicating. They also highlighted the need for parents to work alongside teachers and healthcare providers to improve adolescent SRH. They outlined the specific roles of teachers, school-going adolescents, and parents in implementing the policy for preventing and managing learner pregnancy in schools. The responsibility to report a learner's pregnancy lies with the learner or parent. However, school health practitioners, primarily teachers, mentioned that they often become aware of a student's pregnancy after the fact. Then, they start a conversation about supporting the learner academically, both to the learner and the parent.

> *So what will happen is, the parent will come in with the child, and then the SBST member will take the child and the parent to the Principal's office, and they will discuss certain things that are about the child's pregnancy. They will see how far along the child is or the learner… it's also like a basic interview process …or a meeting process. Whatever the Principal states will be written on the paper provided, and what the parent says will go onto the paper provided… like I said, we are also very strong about promoting education while the learner is pregnant. We will tell the parents that if the doctor booked the learner off, it's still the parent's or the family's responsibility to get the (school) work done. However, the school is not responsible for giving or getting the work to the learner. We are there to give the work, but we are not there to drop the work off or to do house visits or whatever. It's the family's responsibility to come to school and to come to collect the work… and… Without that form, I don't think they will allow the learner because we need to know that the learner is medically fit to be back at school.*
> *Interview 056, CSA, Female.*

Participants mentioned that each school has policies, hence the variation in school-based ASRH interventions and responses to the provision of contraception to adolescents. She mentioned that, at times, provincial departments interpreted national policies differently, which could cause confusion and frustration about what to implement.

> *I'm not saying there shouldn't be policies; there should be policies… (but there's) another challenge of contradicting information: one doesn't know whether it's the National Government's policy or the national education policy down to the provinces, or is it each*

province with its own because there is different information that we are getting….
Interview 058, Teacher, Female.

Views about the service offering

Participants reported that comprehensive sexuality education (CSE) is a valuable and appropriate intervention for adolescents, and they made value-based judgments about adolescents in the process. Teachers and CSAs indicated that school-going adolescents are educated about contraception through CSE, which is presented through life skills or life orientation classes. Other interventions included educational campaigns and peer-education programmes on identified topics such as adolescent pregnancy.

I personally feel that it's very valuable… that you can help an uninformed teenager. You know you can reach the one who needs the…the ignorant one…. and… educate them of the negativities of irresponsible sexual behaviour.
Interview 055, Teacher, Female.

Participants recognised the role of teachers in curriculum-based education, which is stipulated in the *Integrated School Health Policy*. However, they suggested that healthcare professionals should provide information about contraception and administer methods to meet the healthcare needs of adolescents.

I do not think that it's only teachers who are dealing with pregnant girls; I think nurses are also dealing with teenage pregnancies, so if there could be a link or a collaboration between the Education schools and clinics, you know, a school has a Nurse that is stationed at the school.
Interview 058, Teacher, Female.

Participants reported that some schools implemented outreach activities conducted by nurses to make contraception services more accessible for adolescents. Those outreach activities varied from school to school and were coordinated by the CSAs or members of the SBST in collaboration with primary healthcare nurses and civil society organisations.

…through the local clinic, which is nearby here, we have scheduled visits from the nurses who come and talk prevention to the learners [students]….
Interview 043, School Principal, Male.

A few participants reported that the nurses used school halls, libraries or mobile units to consult with the learners. This service was provided by nurses from the local clinics or non-governmental organisations (NGOs) on a monthly, bi-monthly or quarterly basis, which saved the adolescents from long waiting times. However, all the participants reported that learners had to obtain parental consent before attending any SRH programme that was not part of the school curriculum.

…just two months ago…I told the Sister [nurse] not to come because we now have a new programme called (name of NGO). So they're busy getting their clinic up and running for the girl learners and the boys because they are interested in HIV testing….
Interview 059, CSA, Female.

Disparities in knowledge

School health practitioners identified gender disparities in the focus of contraception interventions. The participants were concerned that contraception interventions aimed at educating adolescents on contraception or contraceptive methods were targeted at girls. They highlighted the need for educational interventions that will improve adolescents' understanding of the negative consequences of risky sexual behaviour, suggesting a shift in existing strategies.

From a scale from…zero to 100, I'll say boys are 40% because their mentality is…it's the female's responsibility. Girls, I'll say 80% know about it, but they lack the 20 because they know if you go there and get an injection, 99.9% you are not going to get pregnant. But they don't know the side effects, you know what I mean. … they're lacking. They don't know the pros and the cons, as I said….
Interview 051, CSA, Female.
…I don't want to lie, it's a girl learner [student] always that is involved in the contraceptive awareness, and we left our boys behind, and that is a danger we are doing as adults or as education department, because boys, the boy child also need to be aware of the consequences of getting a learner pregnant or … leaving a learner with STI and other infections….which is not fair for the girl child as if now they are…culprits… It's not the right thing.
Interview 006, Teacher, Female.

Reflecting on her experience, a participant suggested that engaging the community, such as members of the school governing body, could serve as an effective platform to enhance communication about SRH. The involvement of community members would also enable them to participate in interventions aimed at improving contraception

access for adolescents and possibly be better informed about it.

…. And even creating that awareness during parents' meetings making parents aware as well, I think it can help us when we have someone like a representative like (name of another teacher) to make parents aware of certain circulars ….
Interview 061, Teacher, Female.

Theme 2: acceptability

Acceptability refers to the degree to which health services meet the cultural and social norms and needs of healthcare users. This involves recognising the socio-cultural values embedded in the communities the learners come from, parental support, and the values of practitioners. Our analysis found three subthemes: different strokes for different folks, inadequate support for practitioners, and support for pregnant and parenting adolescents.

Different strokes for different folks

Participants highlighted the influence of socio-cultural norms and the home environment. They also mentioned that some boys could be inclined to explore since they are young, which could involve engaging in unprotected sexual activity despite knowing the associated risks.

… you know what our young boys' problem is? They still want to try it out to see if it is really true. Is this really going to happen, and umh, this is not a race thing or a racism thing now, but I'm sorry to say, but in our …community…our mind has been so negatively programmed.
Interview 063, CSA, Female.

Participants emphasised the influence of the social circle (parents, friends, partners) and social environment on learners or adolescents. They mentioned that many learners came from communities where discussions about sexually active adolescents and contraception were considered taboo.

…You know…our school is mixed. So, our learners come from different backgrounds and religious beliefs…. and so we have to take that into account. For instance, this is an Islam community, and it is against the Islam religion….
Interview 067, Deputy Principal, Male.
Lots of times the boys persuade them you know that they love them and that they should have a baby, or they are in a friend group where everybody has a baby, so you know those are strong influences. And if the community or where they come from, umh, if that is the norm, then it becomes very difficult, even with all the education that we give to them… So that is a big problem.
Interview 054, School Principal, Female.

Participants suggested that misconceptions about contraception among some teachers, learners and parents, as well as stigma, influenced the acceptance of contraception interventions among adolescents.

There is a lot of stigma…in the community…. against the people who are sexually active… creating rumours about one another…even the mindset of maybe older people… not that I'm stereotyping our parents. But sometimes you know parents just think of one thing, that…the Health Department is coming out to… promote sex, or teenage pregnancy….
Interview 056, CSA, Female.
We cannot run away from the provision of contraceptives… But it doesn't give them the right to be engaged in sexual activities, yah… But they can misinterpret that they are being given a mandate or whatever, a right, to have to do sexual activities….
Interview 032, Teacher, Male.

Inadequate support for practitioners

Some participants, who were mainly teachers, lamented the inadequate support the education department provided (to) them. In addition, they were concerned about the top-down approach in the policymaking process, the practical implications of implementing some of the policies (for teachers and learners), and the capacity of teachers to implement SRH policies adequately.

… sometimes we feel as if—I personally feel as if we are left on our own—and sometimes these things are given, policies are given from up above to us, without us asking any questions, and we must just implement… But as I said before, really, the challenge is way too much for us. We are not rejecting them, but we would like whoever is coming up with policies to be more… to think deeper, involve schools more….
Interview 058, Teacher, Female.

Some participants reported that they encountered challenges in providing CSE and coordinating ASRH interventions. They indicated that there was inadequate technical support and training for practitioners to enable them to assist learners without any judgment or discrimination.

"…there's such a lot that they [education department] implement, but it's on us here at the school.

When push comes to shove, then it's us. We must be… accountable should something go wrong.… If something happens to the child, it's my responsibility. Where were you? How did you assist the child?' I don't know how to assist the child."
Interview 008, Teacher, Female.
"…We don't feel that we are free to complain about it, because many times it comes from above down to us, all you must do, you must implement… Whereas maybe there should be a dialogue before… I'm not saying there was no dialogue, but by the looks of things, things, we've got a lot of questions as people who are working with teenage pregnancy. Yes, we've got a lot of questions: didn't they think of A? Didn't they think of B? When do I do C when my hands are full of A and B? Do you understand?
Interview 061, Teacher, Female.

Support for pregnant and parenting adolescents

Some participants reported that the education department has a support programme for pregnant and parenting adolescents. The programme entails providing first-time mothers with psycho-social support and a basket of items for the newborn. The participants believed that the programme creates a social inclusion and stigma gap between those participating in the programme and those who do not have access to a similar, including adolescents who were not sexually active and had never been pregnant. Furthermore, this programme could potentially widen the gender gap among adolescents.

The only thing that the education is doing is they are not… I won't say they're not focusing on prevention, but they are focusing more on that team that already has babies. Those that are already moms.… they're supporting them more than the prevention.… I think for me personally.… I would say that let's focus on those learners that are not parents yet.… Because now… it's almost like we… we are enabling these learners that are already mothers because you know they get bags from the department for their baby… toiletries and blankets.…
Interview 002, CSA, Female.

A few participants were concerned that the programme could inadvertently make adolescent pregnancy or parenthood seem appealing because participants received "gifts" from the department. They reported that some adolescents who had participated in the programme became pregnant again. Further, they mentioned that the programme appeared to create an expectation that the department and teachers would help pregnant and parenting adolescents with the needs of their newborn offspring.

… I don't know how that changes the thought of not having a second baby. I think one year, we had a grade 12 girl. Yes, it wasn't last year… I think it was 2021. She had two babies in grade 12: two, two, two (repeats the number 2), one in grade 10 and one in grade 12.
Interview 004, CSA, Female.

One participant was concerned that the programme for pregnant and parenting adolescents was taking them out of the classroom and thus reducing teaching time.

Kids must leave the class now to go sit in that session in the hall. Now they're going to skip like two periods, but at the end of the day, I, the teacher, must ensure that child passes at the end of the year, but …the department is making that platform for them.
Interview 066, Teacher, Female.

Theme 3: adequacy

Adequacy refers to how healthcare is organised to meet users' needs with time, location, and services. This finding is expressed in the perspectives of school health practitioners about how contraception was provided to school-going adolescents. In this study, we identified two subthemes: time and location, and mixed views about making contraceptive methods available.

Time and location

Some participants discussed the importance of ensuring that contraception services are provided adequately to adolescents. They expressed concern about only providing contraception at PHC facilities that operate during school hours (as most schools did not permit the provision of contraception). Questions about the safety of school-going adolescents who require those services came up, as that could influence access. They also pointed out potential barriers to contraception access for school-going adolescents, particularly those living in remote areas (who would require travelling long distances or waiting long for services), raising a question of whether the public sector is providing the right environment for adolescents to receive needed SRH services.

Is it safe to like go to a clinic? Umm, because I know one of our children, like two years ago, they saw was on the way to the clinic, and she got stabbed while being pregnant. So, stuff like that. I don't know if it is safe for our children to go to clinics.…
Interview 001, CSA, Female.

Some participants suggested that school health interventions should include providing on-site contraception services to adolescents in mobile clinics. They argued that this would improve accessibility, save time, and ensure that adolescents feel empowered, have privacy, and do not miss any classes. Furthermore, this could enhance health service provision for both boys and girls and reduce misconceptions about contraception, potentially leading to a decrease in adolescent pregnancy cases.

I envision it happening during school hours, where the school can provide a space. It can be done once a month or once a quarter, but during school hours would work best for me because it's not something that takes up a lot of time.
Interview 053, CSA, Female.
So if they maybe can umm … come to the school and so that it could be their (learners or adolescents) choice, … then they won't (miss) classes. So have one-on-ones or stuff like that. The children can choose to go. Yeah. So that they can see there is help.
Interview 001, CSA, Female.

Mixed views about making contraceptive methods available

Perspectives about providing condoms at schools varied among the participants. While some believed condoms could be given to adolescent boys in need, there was a general reluctance to make them easily accessible to adolescents in a school setting.

…with the HIV/AIDS policy, we should have condoms in the bathrooms, and we don't have. We don't have (condoms) at the moment.
Interview 055, Teacher, Female.
You know…they may be sexually active, but they are still kids, understand. Because at one point where I was before I came here, they were given condoms. They were playing with them, blowing them (makes a blowing sound) understand, so, now you find that they are lying around… Some will just showcase, understand, …so giving condoms to schools I would not appreciate it, I would not appreciate it because they take them as toys to play, understand.
Interview 060, School Principal, Male.

A few participants argued that adolescents should only receive age-appropriate education at school and be encouraged to seek SRH services at local PHC facilities. This suggests that the contraception services offered at PHC facilities were adequate for young people who were in school.

"… if condoms could be distributed in schools, then maybe not the practicality of it but more the educational part of it, and also the information in terms of …where you can access these services, these are contact people so (we) have designated people for that age group, …but also… create a sense of, young people having the, having more courage to go to maybe local clinics and accessing these services.
Interview 026, CSO, Male.
"Any time of the day they can go. If they have a date today, they can go at 10 o'clock, go in and out, and come back to school… they have to show their card to us so that then we can just say, "You can go", and they come back, and it works.
Interview 043, School Principal, Male.

Theme 4: affordability

Affordability refers to service fees that fit the ability and willingness to pay for contraception. Although the policy states that contraceptive methods are freely available at PHC facilities, we found that there may be instances when unexpected costs arise.

When unexpected costs arise

One of the participants reported that contraceptives were not always freely available at PHC facilities in South Africa. He shared an example of a female acquaintance who had to pay for a long-acting reversible contraceptive at a healthcare facility in their rural area. Although only one participant raised this issue, this emphasises the importance of having all PHC facilities provide contraceptive methods free of charge as stipulated in policy guidelines. Further, it highlights the importance of knowledge about policies for healthcare providers and users.

…there was a case where the learner came back to us…saying that they charged her money.... so I said, then don't go to (hospital name) go to the clinic if they charge you, then come back to me then I will go hear what's going on …. because she went to put in that thing (points to the arm)…the implant…she paid R75 (South African currency).
Interview 044, CSA, Male.

Theme 5: quality

Quality refers to the structure and process of providing care. This involves delivering holistic standards of care and contraception services that are focused on the needs of adolescents. In this study, we identified quality as defined by service users as a subtheme.

Quality as defined by service users

Some participants emphasised that quality care should involve safeguarding the privacy and confidentiality of adolescents who use contraception. In addition, they argued that to meet the SRH and contraception needs of adolescents, service provision should be patient-centred, comprehensive and without prejudice.

> *I think it's a bit of… "I'm a bit shy, I'm a bit scared. My dad will see me going there and tell my mom or the clinic sister (nurse) will tell my parents I'm coming to the clinic and have contraceptives or whatever," Ja (Yes). A bit of shyness or not wanting people to know that I am… sexually active….*
> *Interview 067, Deputy Principal, Male.*

Discussion

In this study, we highlighted the perspectives of school health practitioners, who are teachers, CSOs, and CSAs, about providing contraception to school-going adolescents. We organised their insights based on the constructs of Baroudi's conceptual framework on access. These are approachability, acceptability, adequacy, affordability, and quality aspects of providing contraception to learners.

According to Baroudi, providing contraception to adolescents is influenced by sociocultural norms [14]. In this study, participants noted that social factors such as religious beliefs, parents' reluctance to discuss SRH, age-disparate relationships, and poor socio-economic backgrounds are some of the factors that could hinder the provision of contraception to adolescents. Previous research indicates that social norms significantly contribute to the reluctance to use contraception [22, 26, 42]. Providing clear and consistent SRH information from trustworthy sources, such as nurses, could help address these challenges [43]. The Departments of Basic Education and Health should ensure that teachers and nurses are well-equipped to fulfil their different yet complementary roles in enhancing adolescents' contraceptive knowledge. Spreading informative messages about contraception through various media platforms could help dismantle restrictive sociocultural norms while respecting different beliefs [44, 45]. This could improve acceptability and support in communities for adolescent access to contraception [44–46].

Participants highlighted the need to support teachers at the organisational level and adolescents at the interpersonal level. Therefore, the provincial and national Departments of Education should provide training and technical support to teachers who deliver CSE and are involved in implementing the policy on the prevention and management of learner pregnancy in schools. At the interpersonal level, school health practitioners need to understand their biases and values and how these factors could potentially influence the delivery of contraception-related information and services. It is essential for school health practitioners to learn to mitigate those influences and strive to improve rapport with adolescents and their parents. The national and provincial education departments could offer communication workshops to help teachers acquire the necessary skills. Regular communication between parents and teachers could also enhance SRH education and empower adolescents to make informed SRH choices [47].

According to the school health practitioners in this study, adolescents could access CSE in schools. They mentioned that CSE should encompass information on accessing contraception services for young people. Adolescent boys and girls should be empowered to have agency, enhance their knowledge, and make informed decisions about their SRH. The education department could collaborate with the National Youth Development Agency and civil society organisations involved in gender mainstreaming and youth development. Previous studies have shown that intersectoral collaboration is valuable [17, 48]. In our study, participants emphasised that nurses would be best suited to convey accurate information and provide services related to contraception, including CSE and contraceptives, to adolescents. According to the National Contraception Clinical Guidelines, nurses are trained to provide age-appropriate, medically accurate CSE as well as the full range of contraceptives without infringing on the rights and religious beliefs of others [32]. At the same time, the Integrated School Health Policy acknowledges the role of teachers in providing CSE [18]. This places the responsibility on schools to develop suitable and context-specific policies and procedures. While this approach may be commendable, it does not fully address the knowledge gap regarding the prevention of unintended pregnancies and the use of contraceptives. The involvement of parents is vital for promoting ASRH and could help mitigate the influence of societal pressures on adolescents and foster a healthy, secure environment for them [43]. In this context, educational media messaging could include parents. Further, the Departments of Basic Education, Health and Social Development could collaborate with faith-based and other civil society organisations to facilitate workshops for parents and their children on SRH matters.

Adequacy refers to the availability of contraceptive methods and services to school-going adolescents. The idea of providing contraceptive methods to learners in schools generated different views among participants. However, school health practitioners recognised the importance of having easily accessible clinics and nurses in schools to ensure holistic care for both boys and girls

and safeguard their privacy and well-being. Although school-based interventions require human and financial resources, they offer learners access to contraception information and services [17, 48]. Further, learners would not experience long queues and waiting times when accessing contraception services at school [24, 25]. The Department of Basic Education should consider investing more in rural and remote areas by strengthening school-based interventions with the support of parents and the community.

Affordability refers to how contraception services are organised to meet the needs of adolescents. According to the South African contraception policy, contraceptive methods are to be provided free of charge in PHC facilities [32]. However, one of the participants reported a case involving a PHC facility in a rural area charging a fee for a long-acting reversible contraceptive. Although we were unable to verify the accuracy of the claim, it raises questions about the interpretation and implementation of a national policy. It also raises questions about the underlying motivation for charging a fee, if the report is proven true. Research shows that long-acting reversible contraceptives are typically more expensive but save costs in the long term as they can last for several years [49]. Conducting a study to investigate the service fees for contraception in both public and private healthcare facilities and the ability of adolescents to afford those services would be valuable for gaining insight into the experiences of healthcare users and the implications of the existing fee structure.

Beyond service charges, healthcare users could incur hidden costs associated with visiting healthcare facilities. In a study conducted in five rural communities in Australia, it was found that healthcare users travelled 30–45 min to see a healthcare practitioner [9]. In South Africa, transportation is essential for individuals who travel long distances to access contraception, such as learners residing in remote areas. The Department of Health should train healthcare providers in policies and oversee their implementation. This would help ensure that there are integrated school health services and continuity in the provision of SRH services to adolescents.

In terms of quality, participants emphasised the importance of safeguarding the privacy of adolescents who use contraception. However, participants mentioned that learners could access SRH interventions only after obtaining parental consent, which could impede adolescents' privacy. Further, it reveals differences in health and education policies. According to health policies, adolescents aged 12 and above could access contraception without parental consent in a clinic [32]. However, the *Integrated School Health Policy* (p.16–17) stipulates that adolescents below the age of 18 years should only be provided with school health services with written consent from a parent or guardian [18]. Therefore, it is crucial for the Departments of Basic Education and Health to conduct advocacy and educational campaigns in communities about contraception policies, interventions and quality standards of care.

Limitations of the study

The research was conducted during school hours, which may have affected how participants responded to the interview questions because of time constraints. The confirmability of the study is limited to the clarification questions asked during data collection, as the transcripts were not shared with the participants.

Conclusions

This study explored the provision of contraception to adolescents from the perspectives of teachers (including school principals), CSOs, and CSAs. Our findings revealed the implications of implementing the Integrated School Health Policy and the Policy on the Prevention and Management of Learner Pregnancy in Schools concerning contraception and adolescent pregnancies.

The study highlights the importance of CSE in facilitating adolescents' access to and uptake of contraception and the role of parents in that regard. It also recognises the roles of teachers and CSAs in implementing SRH programmes. It emphasises the importance of involving nurses in the provision of contraception services to in- and out-of-school adolescents. The study results call for transparent communication among adolescents, parents, and teachers, as well as interdepartmental collaboration, to strengthen access to and provision of contraception for adolescents.

Abbreviations

ASRH	Adolescent Sexual and Reproductive Health
COREQ	Consolidated Criteria for Reporting Qualitative Research
CSA	Care and Support Assistant
CSE	Comprehensive Sexuality Education
CSO	Care and Support Officer
LMIC	Low-and Middle-Income Countries
NGO	Non-Governmental Organisation
PHC	Primary Healthcare
SBST	School-Based Support Team
SMT	School Management Team
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
WCED	Western Cape Education Department

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Author contributions

T.K. developed the concept and methodology of the research study with guidance from O.A. T.K. collected the data for this study and analysed the research findings under the supervision of G.B.B. and O.A. T.K. wrote the article. All the authors (T.K., G.B.B., and O.A.) read, reviewed, and approved the manuscript.

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Data availability
Data is provided within the manuscript. The datasets generated during the study are not publicly available to protect the privacy of study participants.

Declarations

Ethics approval and consent to participate
This study was approved by the Biomedical Research Ethics Committee (BM19/1/24 on 02 June 2022) and the Western Cape Education Department (20220124-9220 on 28 July 2023). All the participants gave their written informed consent to participate in the study. We ensured participant anonymity and confidentiality by using pseudonyms and storing data in locked cabinets and password-protected computer files accessible only to the research team.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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